Catastrophic Illness Assistance Application

Dear Prospective Recipient:

We welcome your application to this program which, if approved, assists individuals with a **catastrophic illness** to fund situations which may not be funded through other sources. The limit for fund requests is **$500**. The committee reviews applications monthly.

This program is for uncovered medical expenses and costs associated with traveling to medical appointments and other expenses incurred as a direct correlation to the illness.

Applications are due by 12:00pm on the last Wednesday of the month to ensure consideration for the upcoming month. Please ensure all required documentation accompanies this application when it is returned to CCNKS. Lack of documentation may result in a delay in the processing of the application and could cause the application to be passed over until the next month's review period.

The completion of this form does not guarantee approval for assistance. You will be notified directly of the committee's decision.

Required Documentation Includes the following:

- ☐ *Application, completed in full*
- ☐ *Proof of Income*
- ☐ *Copies of Any Bills/Items to be Paid with the Funds (if applicable)*
- ☐ *Documentation Related to Diagnosis of Catastrophic Illness*

If you have difficulty completing the form or gathering any of the documents listed above, please contact the office. Exceptions can be made. Please return the completed application, with accompanying documentation to any of the Catholic Charities 3 locations.

THANK YOU!

Salina–Central Office
1500 S. 9th St. / PO Box 1366
Salina, KS 67401
785-825-0208

Manhattan–Branch Office
212 S. 4th St., Ste. 120
Manhattan, KS 66502
785-323-0644

Hays–Branch Office
122 E 12th
Hays, KS 67601
785-625-2644

www.ccnks.org

Catastrophic Illness Assistance Application

Application Date: _____

Person completing application: _____ **Relationship:** _____

Best contact phone number for person completing application: _____

Applicant First Name: _____ **Middle Initial:**_____ **Last Name:** _____

Applicant Address: _____ **County:** _____

City:_____ **Zip Code:** _____ **Applicant DOB:** _____

Best Contact Phone Number: _____ **Cell** **Home** **Work** **Message Only**

Annual gross family income: _____ **Source of Income** _____
(Be sure to include child support, spousal maintenance, social security, disability, and all employment)

Number of persons in applicant's household: _____

Is the applicant covered by private insurance? (Circle) Yes / No

Is the applicant qualified for any government programs? (Circle) Yes / No

Does the applicant have a Social Worker/Service Coordinator? (Circle) Yes / No

Name: _____ **Phone:** _____

Please provide background information about the medical situation:

_____

_____

_____

_____

_____

_____

How will you use these funds if approved?

_____

_____

_____

_____

Applicant Signature: _____ Date: _____

Interviewer Signature: _____ Date: _____

REMEMBER TO INCLUDE PROOF OF ALL HOUSEHOLD INCOME AND ALL DOCUMENTATION RELATED TO THE ASSISTANCE YOU ARE REQUESTING

Catastrophic Illness Assistance Application

OFFICE USE ONLY:

Initials of Staff Receiving Application: _____ **Date:** _____ **Time:** _____ **AM / PM**

_____ **Proof of Income (130% Poverty Level)** _____**Documentation of Illness**

_____ **Documentation of Expenses to be Paid** _____ **Agency Intake Form**

_____ **Completed Application** _____ **Completed Budget Form**

Staff Notes:

_____

_____

_____

_____

_____

For Case Manager Only:

Applicant Review Notes:

_____

_____

_____

_____

_____

Approval Date: _____ **Amount Approved:** _____

Denial Date: _____ **Date Client Notified:** _____

CCNKS - STABILIZATION & OUTREACH SERVICES

PROGRAM APPLICATION BUDGET FORM - *MUST ACCOMPANY APPLICATION*

LAST NAME _____ FIRST NAME _____ DATE: _____

INCOME SOURCES & AMOUNTS FOR LAST 30 DAYS

□ Earned Income	$_____	□ General Assistance	$_____
□ Unemployment Insurance	$_____	□ Retirement Income from Social Security	$_____
□ Supplemental Security Income (SSI)	$_____	□ VA Non-Service Connected Disability	$_____
□ Social Security Disability Income (SSDI)	$_____	□ Pension from a Former Job	$_____
□ VA Service Connected Disability Compensation	$_____	□ Child Support	$_____
□ Private Disability Insurance	$_____	□ Alimony or other Spousal Support	$_____
□ Worker's Compensation	$_____	□ Other	$_____
□ Temporary Assistance to Needy Families (TANF)	$_____	**TOTAL**	**$**_____

NON -CASH BENEFITS AND AMOUNTS CURRENTLY RECEIVING **Please check box even if amount is unknown.**

□ SNAP/Food Stamps or money for food on a benefits card	$_____
□ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	$_____
□ TANF Child Care Services/Transportation Services/Other TANF Services	$_____
□ Section 8, Public Housing, or Other Rental Assistance	$_____
□ Other Source	$_____
□ Temporary Rental Assistance	$_____
□ Child Support	$_____
TOTAL	**$**_____

EXPENDITURE TYPES AND AMOUNTS FOR LAST 30 DAYS

□ Rent/Mortgage	$_____	□ Car Payment	$_____
□ Electricity-Utility	$_____	□ Gasoline (Vehicle)	$_____
□ Gas/Heating Oil - Utility	$_____	□ Insurance (Vehicle)	$_____
□ Sewage/Trash	$_____	□ Child Care (Personally Paid)	$_____
□ Telephone-Home	$_____	□Health Insurance (Personally Paid)	$_____
□ Cell Phone	$_____	□ Withholding Tax	$_____
□ Water -Utility	$_____	□ Fines/Tickets/Restitution Payments	$_____
□ Food (Excluding Food Stamps)	$_____	□ Other _____	$_____
□ Medical (Dr. Copays/Prescriptions)	$_____	□ Other _____	$_____
□ Transportation (Bus Passes/Cabs/Uber	$_____	□ Other _____	$_____
		TOTAL	**$**_____

TOTAL HOUSEHOLD INCOME AND NET INCOME

Household Income $ _____ Net Income $ _____

REASON FOR ASSISTANCE (Please only check the primary reason for requesting assistance)

□ Not Working/Seeking Work	□ Medical-Short/Long Term	□ Caring for Sick/Disabled Family	□ Fire
□ Sudden Job Loss	□ Eviction - Non-Payment	□ Weather/Natural Disaster	□ Crime Victim
□ Release from Incarceration	□ Property Condemned	□ Unexpected Expense (non-medical)	□ Homelessness
□ Non-Livable Wage	□ Moving/Newly Relocated	□ Family Disruption	□ Other

OUTSIDE FUNDS USED BY APPLICANT

□ LIEAP	□ Salvation Army	□ Red Cross
□ Local Social Service Agency	□ Local Food Bank	□ Church _____
□ Project Deserve - Gas	□ Women Helping Women (Salina Only)	□ Direct Prescription Assistance
□ Share The Warmth	□ Other: _____	

RELEASE OF INFORMATION: I verify that the information I have provided above is true and correct. I consent to the release of pertinent information contained the spaces above to CCNKS as necessary to determine my eligibility and provide services applied for.

Applicant Signature: _____ Date: _____ Staff Signature: _____ Date: _____

CMH 11/2021